# COVID-19 Immunization Screening and Consent Form for Ages 12+

## ☐First Dose ☐Second Dose ☐First Booster ☐Second Booster

| Recipient Info | | | |
|---|---|---|---|
| **Recipient Legal Name** (please print) | | | **Date of Birth** (MM/DD/YYYY) |
| **Sex Assigned at Birth** (check one)<br>☐ Male<br>☐ Female<br>☐ Choose not to Respond | **Phone** | ☐ **Is this a US or Canada Mobile Phone Number?**<br>☐ **Opt-In for SMS (Text) Notifications** (Msg & Data rates may apply) | |
| **Address** | **City** | **State** | **Zip** |
| **Email Address** | | | |
| **Race** (check one)<br>☐ Native American or Alaskan<br>☐ Asian<br>☐ African American or Black<br>☐ Native Hawaiian or Pacific Islander<br>☐ White<br>☐ Other or Multiracial<br>☐ Declined | | **Ethnicity** (check one)<br>☐ Hispanic<br>☐ Non-Hispanic Origin<br>☐ Unknown<br>☐ Declined | |
| **Mother's Maiden Name** (please print) | **Primary Vaccine Type** (check one)<br>☐ Pfizer<br>☐ Moderna<br>☐ Janssen (Johnson & Johnson) | **Date of 1st Dose** | **Date of 2nd Dose** |
| ☐ **Check if you are moderately or severely immunocompromised and received a 3rd Dose in your primary series.** | **Date of 3rd Dose** | **1st Booster Vaccine Type** (check one)<br>☐ Pfizer<br>☐ Moderna<br>☐ Janssen (Johnson & Johnson) | **Date of 1st Booster** |
| **Emergency Contact** | **Relationship to Recipient** | **Emergency Contact Primary Phone** | |

| Screening Questionnaire | | | | |
|---|---|---|---|---|
| 1. | Are you 12 years of age or older and registering for a COVID-19 Pfizer vaccine? | ☐ Yes | ☐ No | |
| 2. | Are you 18 years of age or older and registering for a COVID-19 Moderna vaccine? | ☐ Yes | ☐ No | |
| 3. | Are you 18 years of age or older and registering for a COVID-19 Janssen vaccine? | ☐ Yes | ☐ No | |
| 4. | If registering for a 2nd Booster vaccine, are you 50 years of age or older? | ☐ Yes | ☐ No | |
| 5. | Are you feeling sick today? | ☐ Yes | ☐ No | ☐ Unknown |
| 6. | In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure? | ☐ Yes | ☐ No | ☐ Unknown |
| 7. | Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? If yes, when did you receive the last dose? | ☐ Yes | ☐ No | ☐ Unknown |
| 8. | Have you ever had an immediate allergic reaction (e.g., hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything? | ☐ Yes | ☐ No | ☐ Unknown |
| 9. | Are you pregnant or considering becoming pregnant? | ☐ Yes | ☐ No | ☐ Unknown |
| 10. | Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system? | ☐ Yes | ☐ No | ☐ Unknown |
| 11. | Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments? | ☐ Yes | ☐ No | ☐ Unknown |
| 12. | Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner? | ☐ Yes | ☐ No | ☐ Unknown |

| | | | | |
|---|---|---|---|---|
| 13. | Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)? | ☐ Yes | ☐ No | ☐ Unknown |
| 14. | Do you have a history of MIS-C or MIS-A (Multisystem Inflammatory Syndrome in Children or Multisystem Inflammatory Syndrome in Adults)? | ☐ Yes | ☐ No | ☐ Unknown |
| 15. | If you had a previous dose of Janssen (Johnson & Johnson), did you develop thrombosis with thrombocytopenia syndrome (TTS)? | ☐ Yes | ☐ No | ☐ Unknown |
| 16. | Have you had Guillain-Barre Syndrome after receipt of the Janssen vaccine? | ☐ Yes | ☐ No | ☐ Unknown |
| 17. | Have you received a previous dose of a non-FDA authorized or approved COVID-19 vaccine authorized by the WHO but not by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm/BIBP, COVAXIN)? | ☐ Yes | ☐ No | ☐ Unknown |

**Consent**

I have been offered and/or provided a Vaccine Information Fact Sheet or Emergency Use Authorization (EUA) for the COVID-19 vaccination I am requesting. I have read, or had explained to me, the information sheet about the vaccine. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses to be considered fully vaccinated. Further, I understand that a booster dose(s) of COVID- 19 vaccine may be recommended (as applicable) to increase my protection.

I have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I authorize release of all information needed (including but not limited to medical records) for public health purposes, including reporting to applicable vaccine registries.

**Recipient/Surrogate/Guardian (Signature)** **Date/Time** **Print Name** **Relationship to Patient** (if other than recipient)

**Telephonic Interpreter's ID #** **Date/Time**
**OR**

**Signature: Interpreter** **Date/Time** **Print Interpreter's Name and Relationship to Patient**

**Area Below to be Completed by Vaccinator**

**Which vaccine is the patient receiving today?**

| Vaccine Name | Administration | | | | | Manufacturer & Lot # |
|---|---|---|---|---|---|---|
| Pfizer/BioTech | ☐ 1st Dose | ☐ 2nd Dose | ☐ 3rd Dose | ☐ 1st Booster | ☐ 2nd Booster | |
| Moderna | ☐ 1st Dose | ☐ 2nd Dose | ☐ 3rd Dose | ☐ 1st Booster | ☐ 2nd Booster | |
| Janssen | ☐Single Dose | ☐ 1st Booster | ☐ 2nd Booster | | | |

| | | | | |
|---|---|---|---|---|
| Administration Site | ☐ Left Deltoid | ☐ Right Deltoid | ☐ Left Thigh | ☐ Right Thigh |
| Dosage | ☐ 0.5 mL | ☐ 0.3 mL | ☐ 0.25 mL | ☐ 0.2 mL |

☐ I have provided the patient (and/or part, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____

Updated April 14, 2022